PEDIATRIC PROFESSIONAL ASSOCIATES, P.C.

PRIVACY PRACTICES ACKNOWLEDGEMENT

Patients Name: _____ **D.O.B.:** _____

Parents Name: _____ **Record #:** _____

I have been presented with a copy of Pediatric Professional Associates "Notice of Privacy Practices".

_____ _____

Parent Signature **Date**

For office use only:

If parent refuses to sign, indicate your attempt to obtain a signature below.

_____ _____

Date **Time**

Employee Name: